

DEPARTMENT OF SOCIAL SERVICES

744 P Street, Sacramento, CA 95814

(916) 322-2214



January 20, 1981

ALL-COUNTY LETTER NO. 81-4

TO: ALL COUNTY WELFARE DIRECTORS

SUBJECT: FOOD STAMP OUTREACH PROGRAM - REVISION OF FORM FSOP-1

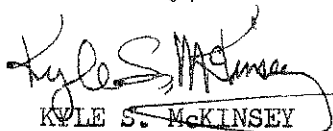
REFERENCE:

This is to provide you with instructions regarding the revised Form FSOP-1, Food Stamp Outreach Contact Report (copy attached). The FSOP-1 form has been simplified and the procedure for completion has been changed accordingly. Please use the following procedure to process the Form FSOP-1 (disregard instructions on printed form):

The county shall ask new applicants if they have been referred by a Food Stamp Outreach worker. If applicants answer affirmatively, then the county shall ask them if they choose to submit a "Release of Information" for their file. The "Release of Information" is Part V of the revised FSOP-1 (see attachment) and should be retained in the case file for six months. If the applicant fails to submit the form, the county shall not delay processing his or her application for this reason and no further action regarding the FSOP-1 is necessary by the county.

Please implement the simplified procedure immediately. If you have any questions or input related to the form or the procedures, please contact the Food Stamp Outreach Unit at (916) 322-4403.

Sincerely,

  
KYLE S. MCKINSEY  
Deputy Director

Attachment

cc: CWDA

**FOOD STAMP OUTREACH  
CONTACT REPORT**

County Welfare Department : Complete Part III.

Retain "Release of Information" in case file  
for 6 months. Submit remainder of form to:**OUTREACH AGENCY:** Complete two copies**FOOD STAMP OUTREACH COORDINATOR**

Department of Social Services

744 P Street, M.S. 15-57

Sacramento, CA 95814

AGENCY NAME	WORKER NAME	DATE
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**I. BASIC INFORMATION**

NAME (LAST, FIRST, MIDDLE)				TELEPHONE NUMBER
CURRENT ADDRESS	(NUMBER)	(STREET)	(CITY)	(ZIP CODE)
CONTACT RESULTED FROM				TARGET GROUP

**II. OUTREACH SERVICES**

	YES	NO		YES	NO	IF YES, LANGUAGE
PRESCREENED	<input type="checkbox"/>	<input type="checkbox"/>	TRANSLATION GIVEN	<input type="checkbox"/>	<input type="checkbox"/>	
REFERRED TO CWD	<input type="checkbox"/>	<input type="checkbox"/>	REFERRED TO OTHER PROGRAMS	<input type="checkbox"/>	<input type="checkbox"/>	(IF YES, LIST PROGRAMS)
TRANSPORTED	<input type="checkbox"/>	<input type="checkbox"/>				
AUTHORIZED REPRESENTATIVE	<input type="checkbox"/>	<input type="checkbox"/>				

**III. FOLLOW-UP**

WAS APPLICATION REQUESTED FROM CWD? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, WHEN? _____ WAS CLIENT CERTIFIED FOR FOOD STAMPS? <input type="checkbox"/> YES WHEN? _____ <input type="checkbox"/> NO WHY NOT? _____	WAS APPLICATION FILED WITH CWD? <input type="checkbox"/> YES WHEN? _____ <input type="checkbox"/> NO WHY NOT? _____
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**IV. FOOD STAMP OUTREACH REFERRAL**

This form is not an application. This is a referral form. If you want to apply for food stamps, take this form with you to the County Welfare Department. Eligibility is determined only by the County Welfare Department.

DATE TO APPLY	PLACE TO APPLY
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\_\_\_\_\_ is being referred to apply for Food Stamps by

(REFERRAL AGENCY)

**V. RELEASE OF INFORMATION**

I, \_\_\_\_\_, Social Security Number \_\_\_\_\_, do hereby  
 authorize \_\_\_\_\_ County to release to \_\_\_\_\_  
 follow-up information pertinent to my application for Food Stamps.

SIGNATURE OF CLIENT

DATE